Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METROCREST SURGERY CENTER

Respondent Name
TASB RISK MGMT FUND

MFDR Tracking Number
M4-10-5245-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
AUGUST 23, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TASB paid $4248.533, an underpayment of $1442.87. Your reason for denying 27680 is that it bundles with 27691, however according to the AAOS, this code is allowed separate payment with the appropriate modifier. I have included this documentation for your review."

Amount in Dispute: $1,442.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3, 2010	Ambulatory Surgical Care Services CPT Code 27680-59-RT	$1,442.79	$1,442.79

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97-Component code 27680; Comprehensive code 27691. The component procedure is integral to accomplishing the comprehensive procedure and is considered included in that procedure. Payment is included in the allowance for another service/procedure.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - 08/12/10-Original audit stands as this charge is considered inclusive.

Issues

1. Is the value of CPT code 27680 included in the value of code 27691?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   According to the submitted explanation of benefits, the respondent denied reimbursement for code 27680 based upon reason code "97."

   On the disputed date of service, the requestor billed: "27691-Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot); and 27680-Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon."

   According to Medicare's National Correct Coding Initiatives (CCI) Edits, CPT code 27680 is global to 27691; however, a modifier is allowed to differentiate the service. The requestor appended modifier "59-Distinct Procedural Service" to code 95920.

   Modifier "59" is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   A review of the submitted operative report indicates procedures performed on the Achilles tendon and the flexor hallucis longus tendon; therefore, the requestor supported the use of modifier "59". As a result, reimbursement is recommended.

2. 28 Texas Administrative Code §134.402(f)(1(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply:
   (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.''

   To determine the maximum allowable reimbursement (MAR) the Division gathered the following factors to be used in the calculations:

   According to Addendum AA, CPT code 27680 is a non-device intensive procedure.

   The 2010 Medicare conversion factor is $41.873.

   The City Wage Index for Carrollton, Texas is 0.9853.

   The fully implemented ASC relative payment weight for code 27680 CY 2010 is 29.6684.

   To determine the geographically adjusted Medicare ASC reimbursement for code 27680:

   The Medicare fully implemented ASC reimbursement rate is found by multiplying the 2010 Medicare conversion factor by the fully implemented ASC relative payment weight = $1,242.30.
   The Medicare fully implemented ASC reimbursement rate is divided by 2 = $621.15

   This number multiplied by the City Wage Index is $612.01.

   Add these two together = $1,233.16.

   To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235%:

$1,233.16 X 235% = $2,897.92. Code 27680 is subject to multiple procedure discounting; therefore, $2,897.92 X 50% = $1,448.96. The respondent paid $0.00. The difference between the MAR and amount paid is $1,448.96. The requestor is seeking a lesser amount of $1,442.79. As a result, $1,442.79 is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,442.79.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,442.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		06/05/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.